



Report to the Legislature

Results of the Dementia Care Pilot Program

Chapter 231, Laws of 2003, Section 9

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Executive Summary

Chapter 231, Section 9, Laws of 2003, requires the Department of Social and Health Services to report to the chairs of the Senate Health and Long-Term Care and House Health Care Committees the results of the dementia care pilot program.

The following details were requested and are included in this report: dementia care standards, the benefits of the dementia care program to residents, and the actual costs of providing dementia care and services to residents under the dementia care pilot program.

Introduction

In Washington State, the number of boarding homes providing specialized dementia care services is expanding, and interest in such services continues to grow. However, in some areas, access to these services by the Medicaid population remains limited.

The Department of Social and Health Services' Aging and Disability Services Administration (ADSA), formerly Aging and Adult Services Administration (AASA), initiated the Dementia Care Pilot Project in Boarding Homes in 1998 as an opportunity for partnering providers and ADSA to collaboratively identify, implement and evaluate standards for specialized dementia care within licensed boarding homes. The standards were intended to promote an effective model of care for persons with Alzheimer's disease or related dementia within the Medicaid service delivery system.

Specialized Dementia Care (SDC) in this project was defined as the special type of care outlined in the *Standards of Care*. This care was to be provided in a licensed boarding home and was to occur in a facility – or a designated, separated unit/wing/program within a facility – dedicated solely to the care of individuals with Alzheimer's disease/dementia.

Through a formal solicitation process, ADSA selected fourteen (14) sites throughout the state and began implementing services, as defined in the pilot project standards, in November 1999. Each of the sites signed a contract to serve between four and ten clients. In total, all sites could serve 103 residents.

ADSA paid pilot project sites in the non-metropolitan statistical areas (Non-MSA) a daily rate of \$80.73 for clients enrolled in the project. Pilot project sites in the metropolitan statistical areas (MSA) were paid a daily rate of \$85.66 for clients enrolled in the project. As of September 2003, the rates were \$85.23 (Non-MSA) or \$90.34 (MSA).

Evaluation of the pilot project occurred through two distinct but connected efforts. First, ADSA contracted with the University of Washington (UW) to evaluate the effectiveness of the pilot project for residents. The UW's evaluation was to cover a two-year period. Over the course of the project, the UW evaluated resident outcomes for 134 residents receiving specialized dementia care in the pilot project sites. During this same time period, the UW evaluated an additional 50 individuals with dementia in 16 traditional boarding home settings for comparative purposes.

Second, ADSA headquarters staff monitored the implementation of the program. To address both project processes and resident outcomes, the ADSA monitoring team developed a process to evaluate understanding of and compliance with the *Standards of Care*.

Design of the Dementia Care Pilot Project in Boarding Homes

Project Sites

The 14 pilot project sites are quite diverse in nature. They are located in approximately 10 different geographic areas of the state, representing both rural and urban communities (McCleary, Moses Lake, Olympia, Selah, Spokane, Tacoma, Tri-Cities, Vancouver, Waterville, and Yakima). Some of the sites are relatively small in size (9-20 residents) while others are quite a bit larger (40 or more residents). Some of the larger facilities are divided into units or wings, making them feel and appear smaller in size.

All of the pilot project sites signed a specific dementia care pilot project contract; five of the sites initially had no other contracts with ADSA, while the other nine sites had at least one other contract with ADSA (in two of the sites, the contracts are for the non-dementia care areas of the boarding home, *i.e.*, assisted living units).

Standards of Care

At the outset of this project, ADSA recognized the importance of service flexibility and had an interest in understanding the varied and creative approaches that would ultimately help in attaining the vision of specialized dementia care. At the same time, ADSA knew it must balance flexibility with the need for clearly defined standards to end up with a useful evaluation of both process and outcome.

An internal workgroup of ADSA coordinated early planning efforts. This group investigated specialized dementia care as it was being delivered in licensed boarding homes in Washington State, how it was developing in other states, and what best or promising practices were emerging across the country, as viewed by experts in the field.

In 1997 and 1998, the ADSA workgroup visited and interviewed all the known specialized dementia care boarding home providers in Washington State. This input from providers was helpful in understanding common and promising practices, priorities, and challenges. The input, along with the information gained from research of other states' programs and practices, and discussions with experts in the field, was consolidated into a background report and discussion tool for use in developing potential standards of care.

At a stakeholder meeting in December 1998, and through additional written feedback from stakeholders, ADSA gathered input about what the standards should be in this pilot project. Additional meetings were held with specific stakeholders, as needed, to refine and clarify details of these expectations.

The *Standards of Care* for the project were published in the solicitation document (request for proposals) that was used as the application and selection document for the pilot project. The *Standards of Care* were divided into five major topic areas: Environmental, Programming, Staff and Staff Training, Assessment and Service Planning, and Family Involvement. The complete set of standards, dated June 1999, may be found in Appendix A.

Program Changes

In the 2002 legislative session, ADSA received funding to offer 60 additional specialized dementia care beds throughout the state. The pilot project was well underway with contracts for 103 beds in the 14 pilot sites. Early implementation experience had already identified several areas that would benefit from refinement if the program should expand. Therefore, several changes were made in regards to project requirements and process. A formal solicitation process (similar to that in the original pilot project) was used to select contractors for the 60 new beds in this expansion phase. The following changes related to expectations and/or requirements were made:

- *Standards of Care* were refined, largely for clarity;
- The time period for completing staff training was extended to 120 days;
- Facilities eligible for these contracts were required to have or obtain either an Assisted Living (AL) or Enhanced Adult Residential Care (EARC) contract with DSHS in addition to the specialized dementia care contract; and,
- Monitoring responsibility for the expansion project facilities was given to the Residential Care Services (RCS) Division of ADSA; specific components for monitoring these contract *Standards of Care* were integrated into the standard boarding home license inspection procedures.

In September 2003, when contracts were up for renewal, ADSA brought the Dementia Care Pilot and Dementia Care Expansion Projects together under the Specialized Dementia Care Program in Boarding Homes contract; this meant that all original pilot sites would need to meet the requirement of attaining an additional DSHS contract (*i.e.*, EARC or AL). The updated standards also reflected changes in the training section due to the implementation of WAC 388-112, which includes Dementia Specialty Training. The *Standards of Care* (dated September 1, 2003) currently being used by all Specialized Dementia Care Program sites is included in Appendix B.

Benefits of Specialized Dementia Care for the Residents

The benefits of specialized dementia care for the residents are presented here in two sections. First, a summary of findings from the *Client Outcomes Final Report*, submitted by the University of Washington, relates how clients fared over time and in comparison to clients with dementia in traditional boarding homes.

Second, findings from the ADSA monitoring process are summarized. The intent of the ADSA monitoring process was to evaluate providers' understanding of and compliance with the *Standards of Care* and review whether quality of life, quality of care, and health and safety needs were met within the constructs of the program.

University of Washington "Client Outcomes Final Report", October 30, 2003

Introduction and Purpose of the Study

Prior to the initiation of this pilot project, small-scale demonstration projects had indicated that special dementia programming might improve resident function and/or delay the need for skilled nursing supervision. Yet such projects had not been conducted on a larger scale.

ADSA was interested in increasing the capacity of residential care programs to meet the needs of individuals with dementia. While specialized dementia care programs were increasing in numbers around the beginning of this program, they were doing so without any defining standards of care or guarantee that such programs would be cost-effective. Before developing a statewide program, ADSA wanted to investigate and evaluate potential standards of care in light of their costs and effectiveness for the residents. To this end, ADSA contracted with the University of Washington to investigate the effectiveness of a specialized dementia care program for state Medicaid clients with dementia who are at risk of nursing home placement.

Overview of Research Design

The Dementia Care Pilot Project in Boarding Homes implemented a Specialized Dementia Care (SDC) intervention in 14 participating boarding homes across the State of Washington.

Medicaid recipients with a diagnosis of dementia who met eligibility criteria and agreed to participate in the research project were evaluated at baseline and after 6, 12 and 18 months to assess benefits of the SDC program.

A comparison group of Medicaid residents with a diagnosis of dementia who met eligibility criteria and agreed to participate in the research, who resided in 16 different traditional care (TC) boarding homes, were evaluated at the same intervals. Resident interviews were conducted at the site where the resident lived.

Family and staff questionnaires were completed at the time of the interview, either in person or by mail.

ADSA selected, trained and monitored the participating SDC boarding homes. ADSA case managers (with consent of the resident and a family member or representative) referred eligible residents in both the SDC and TC boarding homes to the University of Washington (UW). The UW research evaluation team then assessed the impact of the special programming on resident outcomes.

Research Questions and Rationale

- Do residents of Specialized Dementia Care (SDC) boarding homes experience different outcomes than residents of Traditional Care (TC) boarding homes?
- Does residing in a SDC or TC boarding home delay placement in a nursing home, other more restrictive facility, or death?

Summary and Conclusions

The following are findings published in the *Client Outcomes Final Report*:

- Specialized Dementia Care boarding homes served a more severely cognitively impaired and behaviorally disturbed group of DSHS clients than Traditional Care boarding homes. At baseline, 6, 12 and 18-month assessments, SDC residents had lower Mini Mental State Examination (MMSE) scores (indicating lower cognitive functioning) and higher scores on measures of agitation and disruptive behaviors. Despite this greater level of impairment, residents in SDC boarding homes had 1/3 the risk of nursing home placement within 18 months.
- Despite the more challenging resident population served in SDC boarding homes, frequency of pleasant activities was significantly higher in SDC than in TC. This indicates that SDC boarding homes were more successful than TC boarding homes at identifying appropriate activities and encouraging residents to participate in them.
- Families of residents in SDC boarding homes reported higher levels of satisfaction with their family member's care than those in TC boarding homes at each assessment point. There was no change in the overall high level of family satisfaction with SDC over time. Objective observations by project staff during assessment visits also indicated significant differences in overall dementia care quality.

- During the course of this investigation (18 months), the average length of stay in SDC prior to NH placement was 155 days longer than the average length of stay in TC, despite greater cognitive and behavioral disturbance in SDC residents. Based on prior studies of the average rate of cognitive decline in individuals with dementia, combined with our current findings regarding average scores on the MMSE prior to NH placement, length of stay would be projected at approximately two years longer in SDC compared to TC, if the study had been continued until all subjects reached endpoints.
- In summary, it appears that SDC boarding homes are providing an alternative to nursing home placement for individuals with moderate to severe dementia. They admit and retain residents with dementia, despite increasing cognitive and behavioral disturbance, and provide services that most family members rate as either good or excellent.

The full *Client Outcomes Final Report* may be found in Appendix C.

ADSA Monitoring of Resident Outcomes

Concurrent with the UW study of outcomes, ADSA developed a monitoring process to evaluate understanding of and compliance with the *Standards of Care* so that a useful evaluation of both project process and resident outcomes could occur.

The monitoring process and materials focused solely on how resident needs were being addressed within the pilot project *Standards of Care*. All processes related to boarding home licensing and complaint investigation continued according to standard protocol. The monitoring team communicated with ADSA licensing and case management staff during the preparation for each visit.

Monitoring visits included on-site observation, interviews of the residents, family members and facility staff, and records review to assure that the dementia residents included in the pilot project were having their quality of life, quality of care, and health and safety needs met.

In teams of two, nine ADSA headquarters staff members implemented monitoring visits at each of the 14 sites between January and December 2000. Sites were then visited a second time between November 2000 and December 2002. A brief summary of findings from these visits, as they relate to the *Standards of Care*, follows.

Summary of Findings - The First Year

During the first year of implementation, visits to the 14 pilot sites by the ADSA monitoring team revealed that specialized dementia care sites were meeting basic care needs, but not all delivered the care envisioned with the enhanced rate. Some

project sites were providing care approximating the requirements; others struggled with meeting expectations, particularly in the areas of individualized care planning, individualized programming and staff training.

What became clear during this early stage of the project was that the contract *Standards of Care*, along with an orientation session, did not lead to full compliance with the contract. The monitoring team surmised that factors contributing to inconsistent provision of care might include: different “visions” of specialized dementia care held by providers; the only contract enforcement possible was terminating the contract; and, insufficient ADSA staff time to adequately support the provision of care (*i.e.*, training, monitoring and consultation). In short, experience within the first year indicated that providers needed additional clarification and assistance in meeting many of the *Standards of Care*.

Based upon these findings, the ADSA monitoring team recommended the following changes be made, should the program be expanded:

- Refine *Standards of Care* to clarify expectations;
- Refine contract procedures to promote compliance (*i.e.*, more rigorous entrance into program, “teeth” in the monitoring process);
- Increase ADSA monitoring capability;
- Allot more staff time and support at headquarters (*i.e.*, ADSA program manager dedicated to this project);
- Have an ongoing ADSA workgroup with representation from divisions involved;
- Increase provider training and consultation component; and
- Increase awareness and knowledge of case managers and family members so that they know what to expect and can advocate on behalf of the residents.

Summary of Findings - The Second Year

ADSA took steps during the second year of the pilot project to promote more consistent compliance with the *Standards of Care*. ADSA offered training on “Individualized Care for Persons with Dementia: Challenge and Strategies” for pilot site staff. Additionally, the monitoring team began to require facilities, after a monitoring visit, to develop a plan to correct any deficiencies in meeting the *Standards of Care* identified during the visit.

The second set of monitoring visits did reveal improvement in meeting the *Standards of Care*. The issues of individualized care planning, individualized programming, and meeting staff training requirements, however, still presented challenges for several of the project sites. These appear to be areas in which facilities may need initial and ongoing training and support in order to meet the expectations outlined in the *Standards of Care*.

Feedback from Family Members

This pilot project required that there be an involved family member or resident representative for each resident participating in the research component of the project's evaluation.

Family member input is critical in the monitoring process for two reasons. First, clients with dementia have opinions and views to share but are not likely to be reliable informants about the details of care. The family member serves as an informant on the resident's behalf.

Second, family members are key players in specialized dementia care. The *Standards of Care* set the expectation for family members to be viewed as a resource both during the admission process and on an ongoing basis.

Family members were very willing to participate in the monitoring process and eager to share their insights about their family member's care. The semi-structured interview asked both general questions about the resident's experience and more specific questions related to implementation of the *Standards of Care*. These interviews helped to detect individual client concerns or facility issues/trends that aided greatly in the monitoring process.

Responses from family members during the monitoring process were generally positive in regards to overall satisfaction. They were clearly grateful to have a residential setting available for their loved ones and often stated a preference for this type of setting in lieu of a nursing home.

The monitoring team found this general satisfaction even in facilities that were not fully meeting the *Standards of Care* (although, there was often more significant negative family feedback in some of these situations). This may suggest that families do not have a clear framework from which to "evaluate" specialized dementia care (*i.e.*, they do not know what they should expect or what constitutes quality dementia care).

The monitoring team recognized, through this part of the process, the great need to raise awareness among family caregivers about specialized dementia care (*i.e.*, what specialized dementia care should look like, and how to advocate with providers to meet the needs of family members with dementia in this setting).

Despite the general satisfaction of family members, a common issue during family interviews emerged during the first year. Communication between the families and among facility staff can be a challenge. In certain facilities, families expressed a frustration that the facility did not seem to "recognize" the changing needs of a client (*e.g.*, decline of function). Families expressed frustration that repeated attempts to improve care by talking to a staff member were unproductive. They frequently did not know whom, in specific, to talk to; or, when they did speak to someone, they found that the situation did not improve,

which may imply a lack of communication between staff members. This issue of communication, viewed as critical in providing quality care for this population, was directly addressed in the revision of the *Standards of Care* as the program expanded.

Families also questioned whether their family member was as involved as he/she could be in programs and activities. This arena of programming represents an ongoing challenge for providers and deserves further attention in terms of research, training and support.

Actual Costs Of Providing Specialized Dementia Care

To determine actual costs of providing specialized dementia care and services to residents under the Dementia Care Pilot Project in Boarding Homes, ADSA designed and conducted a staff time measurement study and a cost survey in facilities contracted under the dementia pilot program.

Staff Time Measurement Study

The time study was designed and conducted by ADSA in 2001. The purpose of this study was to record actual staff time used in providing dementia care and services. This study gathered actual staff time spent with each resident in providing care and services.

Six providers contracted under the Dementia Care Pilot Project in Boarding Homes participated in the staff time measurement study. Department staff trained all facility staff in the use of a hand held computer to record time they spent with residents and time they spent providing facility support. Time spent with residents or resident specific time was any time spent for or with the resident.

If an administrator was talking with a resident's family member this was recorded as resident specific time. Time spent providing facility support would be all other time staff spent while on duty. That is, if a caregiver is helping with clean up or training, etc., this time is recorded as facility support. Time data was collected for three consecutive 24-hour days and the average daily time was used to compute a staff cost for each of the 44 residents participating in the study.

The number of daily staff hours for each resident and the pricing of time data with wage rates from department established benchmarks for operations and capital for each of the six facilities are displayed in the tables in Appendix D.

Based on this time study, the **average cost per resident day** was \$72.06. The range in cost per resident day in these six facilities, for individual residents that participated in the time study, was from \$53.65 to \$94.79.

"Actual Cost" Survey

ADSA surveyed the Dementia Care Pilot Project providers in 2003 regarding their actual cost of operations for providing dementia care and services. Questions were asked in four categories; staffing costs, operating costs, capital costs and residents served. The *staffing* category asks for staff titles, wages, payroll taxes and fringe benefits, and number of hours worked per day. The *operations* category asks questions regarding the 2002 calendar year cost of supplies, utilities, real estate taxes, insurance, advertising, etc. The *capital* category includes the value of land, building, building improvements and

moveable equipment. And the *residents served* category asks for the number of residents served in calendar year 2002.

In early September of 2003, the survey (Appendix E) was sent to all 14 boarding home providers participating in the Dementia Care Pilot Project in Boarding Homes. Providers were asked to complete the survey form and submit it to the department by September 30, 2003. Four of the 14 providers surveyed returned the requested data by the end of September. Follow-up calls were made to the 10 remaining providers early in October, extending the deadline to October 20, 2003. By October 20, a total of six providers had submitted a self-reported survey. The cost data does not represent all the pilot project sites, as less than half of the sites responded to the survey. Note: ADSA is planning to survey all licensed boarding homes regarding costs in early 2004. At that time, more information will be available.

The six sets of survey data, as shown in Appendix F, are used to display the actual breakeven costs (Table 1) per resident day to provide dementia care and services for the average resident. Of the six sets of survey data received, three did not include *capital* and five did not include *residents served* data. Where this data is missing, ADSA used benchmarks selected by the department that are believed to reflect market levels of capital costs and occupancy standards.

Residents served data is essential to develop a per resident day rate when comparing one facility with another, or when averaging all facilities in the sample. Where facilities did not report residents served data, the department benchmarks are substituted. When calculating the number of residents served in calendar year 2002, it is assumed that 88.9% of the facility's licensed beds were occupied throughout the calendar year. For example: Facility Q has 30 licensed beds that are assumed to be 88.9% occupied. The number of residents served in calendar year 2002 is: $(30 \times .889) \times 365$. All annual costs are divided by this product to determine the cost or rate per resident day.

Capital costs are a cost of land, building and equipment used in providing this service. Where facilities did not report capital costs, the department benchmarks are substituted. To establish the cost of land, the median assessed value of 25 randomly selected boarding homes in the same geographic area is used. To this is added the cost to build a new facility, as described by the Marshall-Swift Valuation Service. The cost of moveable equipment based on actual costs reported in the Washington State nursing facility cost data is then added. This combined value of capital is converted to a daily rental rate per resident by applying an annual rate of interest based on the Treasury Composite Index, then dividing by annual resident days.

The **average cost per resident day** of providing specialized dementia care services within the pilot project for these six facilities was \$79.01, with a range of \$57.10 - \$99.47.

Potential Savings as an Alternative to Nursing Home Placement

Risk for nursing home placement is addressed in the *Client Outcomes Final Report* (Appendix C, pages 11-12). Results of findings show the average length of stay in SDC was 442.5 days versus 287.1 days in TC, a difference of 155 days. This was despite the greater cognitive and behavioral disturbance in SDC. By lengthening stays in SDC an average of 155 days over TC, there is a delay, and possibly total avoidance, of nursing home care for some residents.

With the current statewide average nursing home rate of \$140.00 per day and the average dementia pilot rate of \$88.01 per day, a savings of \$51.99 per day is realized. This additional length of stay of 155 days translates to a savings of \$8,058.45 (\$51.99/Day x 155 Days) for each resident. Looking at the 134 residents in the investigation, the potential savings based on these 18-month findings would be \$1,079,832.30 (\$8,058.45 x 134 residents).

Note that this 155-day finding was truncated by the 18-month investigation and the lengths of stay would be longer if all subjects had been followed to the actual date when they reached endpoint. The 18-month investigation found the average MMSE score preceding nursing home placement was 3.7 for SDC, while the average MMSE score preceding nursing home placement was 10.6 for TC residents, an average difference of 7 points. An average rate of decline on the MMSE of 3 points per year has been widely cited in scientific literature on the progression of dementia. Findings from the investigation show an average rate of decline of 3.13 within a 12-month period. Based on these averages, a difference of 7 points on the MMSE at the time of nursing home placement would potentially translate into a postponement in NH placement of approximately two years in SDC over TC.

If in fact the length of stay in SDC were a total of two years longer than the length of stay in TC, the savings per resident would be \$37,952.70 (365 days x 2 x \$51.99). For all 134 residents in the investigation, total potential savings would be \$5,085,661.80 (365 days x 2 x \$51.99 x 134 residents).

Summary of Pilot Project Findings

By piloting this model of specialized dementia care prior to establishing a statewide program, ADSA has collected useful information that can guide the department as it works towards expansion of the program. In analyzing the UW findings and ADSA monitoring information, ADSA has learned the following about implementing specialized dementia care:

Client/Resident Outcomes

- The Specialized Dementia Care (SDC) program serves a more severely cognitively impaired and behaviorally disturbed group of clients with dementia than do traditional care boarding homes.
- Despite a greater level of impairment, residents in Specialized Dementia Care had 1/3 the risk of nursing home placement over the 18 months of the study.
- The frequency of pleasant events was significantly higher in Specialized Dementia Care homes than in traditional care boarding homes.
- Families of clients with dementia in Specialized Dementia Care reported higher levels of satisfaction with care than families of clients with dementia in traditional care boarding homes.
- Specialized Dementia Care services promote aging in place. During the 18-month investigation, the average length of stay for clients with dementia in Specialized Dementia Care was 155 days longer than in traditional care boarding homes.

Costs of Care

The actual costs of providing care for clients with dementia in Specialized Dementia Care, as defined within the pilot project *Standards of Care*, was investigated in two separate efforts conducted by ADSA in 2001 and 2003.

- In the Time Study of 2001, the average cost per resident day of providing Specialized Dementia Care services for pilot project residents was \$72.06 per resident day, with costs of six different providers ranging from \$53.65 to \$94.79.
- In the Actual Cost Survey of 2003, the average cost per resident day of providing Specialized Dementia Care services within the pilot project was \$79.01, with costs per resident day of six different providers ranging from \$57.10 to \$99.47.

Potential Savings

The daily rate, at the outset of this project, paid to contracted providers in this pilot project was \$80.73 (Non-MSA) or \$85.66 (MSA). As of September 2003, the rates were \$85.23 (Non-MSA) or \$90.34 (MSA).

Study results indicate that SDC can delay nursing home placement and, in some cases, possibly prevent it. Looking at the 134 residents in the investigation, the potential savings based on these 18-month findings would be at least \$1,079,832.30.

If, as suggested by the average rate of decline on the MMSE and the trends found in this investigation, we were to have continued this research beyond the 18-month period, the result would likely translate into a postponement in nursing home placement of approximately two years in Specialized Dementia Care over Traditional Care. If the actual length of stay in SDC were a total of two years, the potential savings, for all 134 residents in the investigation, would be \$5,085,661.80.

Recommendations

1. Quality Assurance

Ensure that the facilities participating in the Specialized Dementia Care Program in Boarding Homes are providing specialized dementia care as defined in the Standards of Care (at the enhanced rate).

- A. Provide the training and support needed for new and ongoing facilities throughout the state (preferably locally/regionally based). This might include:
 - Orientation related to *Standards of Care*;
 - Ongoing technical assistance and support re: *Standards of Care*;
 - Support and assistance in meeting training requirements;
 - Support and assistance in meeting client needs; and/or
 - Training of involved case management.
- B. Create mechanism and develop administrative support to enforce contract provisions in a manner consistent with other department contracts (*i.e.*, include in WAC 388-110 along with Enhanced Adult Residential Care, Assisted Living).

2. Increase Service Capacity

Expand the number of beds available for Specialized Dementia Care, for the Medicaid population, throughout the state.

- A. Expand language from Chapter 25, Laws of 2003 E1, Sec. 206, (which authorized 200 additional beds for persons with dementia that are moved to specialized dementia care from a nursing facility) to allow persons with dementia to be admitted to specialized dementia care from *any* community setting, not just nursing facilities.

Note: An unpublished finding from the University of Washington's Client Outcome study was: Of the 134 clients followed in the specialized dementia care program, only one client was moved from a nursing home and one client was admitted from Western State. The remainder of the clients came to specialized dementia care from either their home or a community-based setting. This was despite a concerted effort on the part of ADSA's Home and Community Services staff to identify and make available this program option to individuals with dementia residing in nursing facilities.

- B. Expand the Specialized Dementia Care Program in Boarding Homes, by an additional 200 beds, in fiscal year 2004.

Note: The estimated savings would be a minimum of \$1,611,690 for 155 days, or up to \$7,590,540 if residents remained in SDC for the two years suggested by the pilot project findings.

3. Raise Awareness of Specialized Dementia Care

Establish department workgroup to identify and address the needs of the public, agency staff, and family caregivers in understanding specialized dementia care and advocating with facility staff to enhance care within these programs.

4. Program Improvement

Establish a department workgroup to evaluate and address areas for program improvement.

Note: An unpublished finding from the University of Washington's Client Outcome study indicated that despite positive findings in general, there was room for improvement in the arenas of: behavior management, programming and potentially increasing length of stay for those with medical concerns.

Appendices

APPENDIX A: Standards of Care, June 1999

APPENDIX B: Standards of Care, September 2003

APPENDIX C: University of Washington “Client Outcomes” Final Report

APPENDIX D: Staff Time Measurement Study Data

APPENDIX E: Letter and Survey to Boarding Home Providers

APPENDIX F: Cost Survey Data

DEMENTIA CARE PILOT PROJECT IN BOARDING HOMES: STANDARDS OF CARE

INTRODUCTION

EXHIBIT A

Aging and Adult Services Administration (AASA) is committed to improving consumer service options by expanding the capacity of AASA residential care programs. Specialized dementia care services in the residential setting remain extremely limited for the Medicaid population. To address this issue, AASA is establishing the Dementia Care Pilot Project in Boarding Homes, which will identify and evaluate standards for specialized dementia care within licensed boarding homes. The standards intend to promote an effective model of care for persons with Alzheimer's disease or related dementia within the Medicaid service delivery system.

The attached standards will, at this time, apply only to those facilities - or designated, separate units located within larger facilities - dedicated solely to the care of individuals with Alzheimer's disease/dementia, which apply for and are selected to participate in this pilot project. We recognize the importance of service flexibility and are very interested in understanding the varied and creative approaches that will help us attain the vision of this model. At the same time, we must balance this flexibility with the need for clearly defined standards if we are to end up with a useful evaluation of both process and outcome, which will ultimately guide us towards the opportunity to seek development of a statewide program.

This proposed model is both holistic in nature and based upon meeting individual needs. The resident-centered approach is intended to promote optimum health and quality of life within an environment that accommodates cognitive deficits, maximizes functional abilities, and promotes aging in place. The standards, below, are divided by major topic areas including: Environmental, Programming, Staff and Staff Training, Assessment and Service Planning, and Family Involvement.

1. ENVIRONMENTAL

- A. Small unit (e.g., wing) sizes preferred, larger sizes acceptable when plans for establishing a home-like atmosphere and appropriate levels of stimulation are present.
- B. The facility will offer a mix of private and semi-private rooms. In existing facilities with only semi-private rooms, plans will be in place which: (a) ensure resident privacy and individualized space; (b) promote roommate compatibility (e.g., appropriate matching) without frequent room changes; and (c) outline actions for identifying and dealing with the resident who is unable or unwilling - due to impaired cognition, judgement and impulse control - to share a bedroom.
- C. If toileting and bathing facilities are outside residents' rooms, plans will be developed that promote safe, dignified and timely toileting and hygiene (e.g., written policies, staff training). All bathrooms will be easily identified by residents.

- D. Program offers a non-institutional, home-like atmosphere, for example, no traditional nursing station or public address system. Residents and/or families will be encouraged to decorate and furnish their rooms with personal items and furnishings based on the resident's needs, preferences and appropriateness.
- E. The facility provides for the safety of residents who may wander through increased staffing patterns, devices designed to prevent undetected egress (e.g., door monitoring devices, controlled exits), etc.
- F. The facility provides freedom of movement for the residents to common areas and to their personal spaces. The facility shall not lock residents in their rooms and residents shall have access to their rooms at all times.
- G. The facility provides a variety of walking paths, inside and outside, to encourage physical activity. Residents will have free access to a secure outdoor space that offers level walking paths.
- H. The facility offers different common areas for socialization and meaningful activity (e.g., resident kitchens, garden areas, workshop areas, office area, dining areas, etc.) that vary by size and arrangement.
- I. Facility utilizes appropriate materials and design to accommodate the cognitive deficits of the dementia population, including those that minimize glare and shadows and those that enhance orientation and way-finding.

2. PROGRAMMING

- A. Facilities must provide daily programming appropriate to the needs and preferences of the individual residents. Programming should include planned and spontaneous individual and/or group activities. Self-care activities are integrated into programming as opportunities for purposeful and positive interaction.
- B. The activities that make up a resident's daily experience should reflect, as much as possible, that individual's preferred lifestyle while providing a sense of usefulness, pleasure, success, and as normal a level of functioning as possible.
- C. The facility will utilize family and previous provider knowledge about the resident's life, times and personal experience to develop individualized programming for each resident.
- D. Elements in the structure and layout of the setting should create opportunities for meaningful activity, such as, paths and walkways that encourage exploration and walking, and furniture groupings, such as tables and chairs that encourage stopping and spontaneous social interaction.
- E. Programming is available to residents based upon the best possible evaluation of residents' abilities, interests, habits, and needs. Rather than asking a resident to conform to a set schedule, staff adapts programming and activities into the resident's schedule and

individual interests. For example, individuals up at night will have access to staff support, food and appropriate activities.

3. STAFF AND STAFF TRAINING

- A. Facility will maintain a direct care staff ratio necessary to support residents' physical, psychosocial, spiritual, emotional, health care and safety needs. Staffing will be sufficient to enable each resident to maximize his/her functioning, self-care and independence. Direct care staffing levels recognize that resident needs are not different on weekend days/evenings than from other days/evenings of the week.
- B. Facility will maintain awake staff on the night shift. Staffing will be adequate to respond to the sleeping and waking patterns and needs of residents. Additional staff is available, as needed, for emergency situations.
- C. Locked exterior doors or perimeter fences with locked gates shall not substitute for trained staff in sufficient numbers to meet the care and supervision needs of all residents.
- D. The facility will coordinate and/or provide for resident's health care needs. This may be done by hiring or contracting with: 1) a registered nurse; or 2) a licensed practical nurse working under the supervision of a registered nurse; or 3) an ARNP.

Licensed nursing staff will:

- 1) Provide nursing services as allowed in boarding home regulations and as needed to meet resident needs;
- 2) Provide ongoing health assessment that includes regular observation and assessment of signs of illness or distress;
- 3) Participate as a member of the caregiving team to develop, revise and implement the service plan;
- 4) Be a knowledgeable and available resource to staff regarding resident health care concerns, model appropriate staff/resident/family interaction, and provide assistance and guidance with issues of resident behavior and well-being;
- 5) Provide informal and incidental training related to changing needs of residents; and, may participate in more structured training; and
- 6) Be available at all times through an on-call system to meet unscheduled needs.

A facility may substitute a physician, or a physician's assistant working under the supervision of a physician to accomplish all or part of the duties above, if desired.

- E. Facility will actively seek appropriate consultative resources for clients identified as having unmet psychological or behavioral needs. This may be through a cooperative agreement with a local community mental health center or with a qualified consultant (i.e., mental health professional with experience working with older adults or health professional with geriatric mental health expertise) who will act as a resource in the assessment process, service planning and problem solving, as needed. In communities where a facility is unable to access appropriate resources for consultation or assistance, the department will work cooperatively to assist in accessing such resources.

- F. The facility will provide a comprehensive Alzheimer's/dementia training plan to be approved by AASA. Within the plan, the facility will describe:
- 1) How all staff will be oriented;
 - 2) How the facility will ensure that all staff who work directly with residents, including the administrator, will be able to complete the training curriculum identified below;
 - 3) What training other staff (i.e., staff who don't work directly with residents) will receive;
 - 4) Who will be providing the training, including the skills, knowledge and experience of the selected trainer(s), or the skills, knowledge and experience expected of the trainer to be hired;
 - 5) What training curriculum will be utilized (see note below); and
 - 6) How continuing education, related to Alzheimer's disease/dementia, will be provided.

The goals of the training are to impart an understanding of the overall philosophy of care and how it relates to the daily life of each resident, enhance staff sensitivity toward residents and family members, to allow staff to apply care strategies and techniques *specific to dementia*, and to promote positive staff/resident/family interactions.

At a minimum, the dementia training curriculum will include:

- Resident Rights*;
- Observation and Reporting*;
- Medication Policies and Procedures*;
- Personal care - assistance with mobility and transfers, skin care*; in addition, staff will be expected to know the following skills and information related to personal care: nail care, oral care, shampoo, and bath equipment (a skills checklist will be utilized to confirm knowledge);
- Introduction to Alzheimer's disease and other dementias (including the diagnosis, progression and management of Alzheimer's);
- Communication Skills;
- Behavior as Communication;
- Depression;
- Repetitive Behaviors;
- Wandering;
- Aggressive Behaviors/Catastrophic Reactions;
- Paranoia, Suspiciousness and Hallucinations;
- Intimacy/Inappropriate Sexual Behavior;
- Sleep Disturbances;
- Bathing and Dressing;
- Toileting;
- Eating and Swallowing;
- Activity/Meaningful Interaction;
- Environment: Changes that make a Difference;
- Family/Staff Interaction;
- Care for the Caregiver;
- Multi-cultural Considerations (if appropriate to facility); and,
- End-of-Life Issues (if appropriate to facility).

- * These modules will be made available for project sites as adapted modules from the department's *"Fundamentals of Caregiving"* training.

Note: The department has pre-approved the curriculum entitled *"Providing Dementia Care: A Teaching Manual for Educators"* produced by the Alzheimer's Association of Western and Central Washington in conjunction with four units of the training program, *"Fundamentals of Caregiving"*. Other curriculums must be approved, by the department, on an individual basis; approval will be based upon comparability of topics and learning objectives between the pre-approved training and the facility's proposed training curriculum.

The comprehensive training will be completed by all staff who work directly with residents, including the administrator, within 90 days of hiring. The facility will maintain documentation of all staff training. Staff members with documentation of previous completion of the pre-approved (or department approved) curriculum, are not required to repeat the training or portion(s) of the training already completed.

The facility will utilize a uniform "skills" checklist to ensure each staff trainee (including those who have completed the training previously) is competent in dementia-specific care strategies, as well as specified personal care skills. This checklist will be provided by the department.

- G. Each employee, who works directly with residents, must have at least one hour of continuing education related to Alzheimer's disease/dementia monthly; this may include classroom training as well as group or individual problem-solving sessions facilitated by professional staff.

4. ASSESSMENT AND SERVICE PLANNING

- A. Dementia care is provided only to people who have been diagnosed with Alzheimer's disease or other irreversible dementia, and who have been assessed by the department as needing the care a specialized dementia program can offer.
- B. Building on the department's comprehensive assessment, the facility will do an assessment that evaluates and documents, at a minimum, each resident's unique: health care needs (including nursing and medication needs); personal care needs and preferences; need for psychological or mental health services; social needs and preferences; and safety needs.

The facility's assessment process will also include a review of: the person's daily routines and habits; the person's own sources of self-esteem and pleasure; and, will, in consultation with the department, identify family supports and the role the family intends to maintain in the life of the person with dementia.

- C. Facility staff shall develop a written, individualized service plan (i.e., individual resident plan) that promotes dignity, optimum health and well-being. The plan supports the resident's independence in self-care and daily activities, within a restraint-free environment. It reflects the resident as a person with current and life-long goals, personal history, family and interests, and recognizes his/her particular sources of self-esteem and pleasure.

Family members/resident's representative(s) are included as an ongoing source of information about the resident's life and times, personal experience, values, daily habits and routines. A designated family member/resident's representative(s) shall be notified in a timely manner of service planning sessions and invited to attend. Documentation of such notification shall be kept by the facility.

The service plan:

- Documents the needs of the resident as identified in the assessment process. It addresses areas in which the resident needs assistance or an intervention strategy;
 - Describes how the needs will be addressed, defining who will arrange and/or deliver services;
 - Is re-evaluated semi-annually, if a significant change occurs, or at resident/family/resident representative request, to accommodate changes in abilities, needs and/or goals;
 - Must be approved and signed by the resident or the resident's representative, the facility and the department case manager; the facility will provide the case manager with a copy of the service plan; and,
 - Must be completed within 30 days of admission (move-in).
- D. Assessment and service planning involves the resident and/or resident's representative(s) to the extent possible. When the resident is not able to participate formally, attempts are made, through informal discussions, to understand and integrate the resident's desires and preferences. Resident's preferences should also be determined based on personal history, known preferences and lifestyle, and reactions to events in the current facility.

5. FAMILY INVOLVEMENT

- A. Family members, as defined by the resident, are encouraged to participate in the resident's life and the life of the facility unless the resident chooses not to involve them. The facility will recognize and promote each family's involvement based upon resident desires and needs, and the families desired level of involvement.
- B. The facility, in conjunction with the department, will offer and encourage family members to participate in education sessions, support groups or other format of supportive services related to their family member either through direct provision or referral to appropriate resources in the community.
- C. Ongoing communication and interaction shall be made possible by the facility between family members, providers, and residents. Responsible family members will be kept informed and their input should be requested and welcomed.

DEMENTIA CARE PILOT PROJECT IN BOARDING HOMES: STANDARDS OF CARE

OVERVIEW

Aging and Disability Services Administration (ADSA) is committed to improving consumer service options by expanding the capacity of ADSA residential care programs. ADSA initiated the Dementia Care Pilot Project in Boarding Homes, in 1999, to address this issue. However, specialized dementia care services in the residential setting remain limited for the Medicaid population. ADSA continues to work towards an expansion of specialized dementia care in boarding homes.

The Specialized Dementia Care Program in Boarding Homes will continue to promote an effective model of care for persons with Alzheimer's disease or related dementia within the Medicaid service delivery system. When ADSA received funding for specialized dementia care in the 2002 legislative session, the original project standards were reviewed and refined, largely for clarity, based upon lessons learned from those participating in the first years of implementation. In January 2003, ADSA brought the Dementia Care Pilot Project and Expansion Project sites together by utilizing alike *Standards of Care*, namely the refined *Standards* utilized within the Expansion Project. These *Standards* now also include revisions required due to recent WAC changes related to training.

The attached *Standards* will, at this time, apply only to those facilities - or designated, separate units located within larger facilities - dedicated solely to the care of individuals with Alzheimer's disease/dementia, which participate in the continuation of the Dementia Care Pilot or Expansion Projects. This will now be referred to as the Specialized Dementia Care Program in Boarding Homes.

This specialized dementia care model is both holistic in nature and based upon meeting specific individualized needs. The resident-centered approach is intended to promote optimum health and quality of life within an environment that accommodates cognitive deficits, maximizes functional abilities, and promotes aging in place. The *Standards*, below, are divided by major topic areas including:

1. Specialized Dementia Care Assessment and Service Planning
2. Dementia Care Activities
3. Staff and Staff Training
4. Environment
5. Family Involvement

1. SPECIALIZED DEMENTIA CARE ASSESSMENT AND SERVICE PLANNING

INTRODUCTION

The ability to provide specialized quality dementia care is dependent upon both knowing and understanding the individual as a unique person, and upon ensuring that direct care staff have the basic dementia care skills and resident-specific information required to address each individual residents needs on a daily basis.

The **purpose of the assessment** process is for facility staff to get to know the person and his/her needs, preferences and wants - it is critical to the development of a useful service plan. The **purpose of the service plan** is to direct staff on how to provide services in a highly individualized manner. It is a tool that identifies specifically what the resident needs and how those needs are to be addressed on a daily and ongoing basis.

STANDARDS

The facility shall:

- A. Develop a system for assessing individuals' needs; care provided must accurately reflect individuals' needs.
- B. Complete a **specialized dementia care assessment**, building on the department's comprehensive assessment, that evaluates and documents each resident's unique needs, strengths, likes and dislikes. At a minimum, this is to include:
 - Health care needs (including nursing and medication needs);
 - Personal care needs and preferences. This will incorporate the person's daily routines and habits prior to admittance including, but not limited to bathing, dressing, toileting, sleeping, and eating;
 - Needs for psychological or mental health services;
 - Needs for behavioral intervention strategies or services;
 - Safety needs;
 - Social, activity and spiritual needs and preferences. This will incorporate the person's own sources of self-esteem and pleasure (i.e., what makes the resident feel good about self? feel happy/content?), personality and nature, interests and hobbies;
 - Life history, including family, career, education, life experiences, sources of pride, and familiar roles;
 - Family system. It describes the family (and/or significant others) , how they intend to be involved in the life of the person with dementia, and identifies any support needed by the family.
- C. Develop a systematic process for soliciting input from family members (and/or significant others) for both the initial and ongoing specialized dementia care assessment process.
- D. Develop a systematic process for soliciting input from the direct care staff for both the initial and ongoing specialized dementia care assessment process.
- E. Involve the resident and/or resident's representative(s) in the specialized dementia care assessment and service planning process to the extent possible in order to understand and integrate the resident's desires and preferences based on personal history, known preferences and lifestyle, and reactions to events in the current facility.
- F. Develop a **written, specialized dementia care service plan** that promotes dignity, optimum health and well-being. The plan should focus on the individual's specific needs and ways to enhance life experiences; it will explain to and provide direction to staff on how to provide

services in a way that meets residents' needs and accommodates their preferences (i.e., service plans should vary from individual to individual and for an individual over time).

The plan supports the resident's independence in self-care and daily activities. It reflects the resident as a person with current and life-long goals, lifestyle preferences, personal history, family and interests, and recognizes his/her particular sources of self-esteem and pleasure.

The specialized dementia care service plan shall:

- Address areas in which the resident needs assistance and support. This includes, but is not limited to, directions to staff on how to assist and support residents with the following:
 - Medications and/or other nursing/medical treatment
 - Personal care tasks (i.e., ADL's)
 - Psychological or mental health needs
 - Behavioral concerns
 - Safety
 - Activity and social interaction. This must describe what activities – both planned and spontaneous – are to be encouraged.
 - Describe how each need will be addressed, and by whom. It will identify which caregiving staff will provide the assistance and/or who will arrange services;
 - Be re-evaluated:
 - semi-annually (at a minimum), or
 - when a significant change occurs, or
 - at resident/family/resident representative request, or
 - to accommodate changes in resident's abilities, needs and/or goals;
 - Be approved and signed by the resident or the resident's representative, the facility and the department case manager; facility will provide the HCS case manager with a copy of the service plan; and,
 - Be completed within 30 days of admission (move-in).
- G. Develop a systematic process for soliciting feedback and input from the direct care staff related to the development of both the initial and ongoing specialized dementia service plan.
- H. Notify a designated family member/resident's representative(s) in a timely manner of service planning sessions and invite them to attend as an ongoing source of information about the resident's life and times, personal experience, values, daily habits and routines, and reactions to events in the facility. Documentation of such notification shall be kept by the facility. The facility shall offer a flexible schedule for service planning that accommodates family members' schedules to enable involvement in this process.
- I. Develop a systematic process that provides direct care staff with a working knowledge of the specialized dementia care assessment and service plan information for residents in their care. Direct care staff shall demonstrate the ability to provide individualized care based upon this knowledge.

Communication systems are in place that ensure direct care staff are informed of changes in specialized dementia care assessment and service plan information, and systems are in place for direct care staff to implement these changes.

2. DEMENTIA CARE ACTIVITIES/PROGRAMMING

INTRODUCTION

Specialized dementia care offers opportunities on a daily basis that enable residents to use retained skills, express familiar roles and continue to do the things that are most personally satisfying. The intent is to support personal relationships and self-esteem. Activities are not just contrived experiences; they include the normal things done in the course of each day.

STANDARDS

The facility shall:

- A. Provide daily activities consistent with the needs, functional abilities, interests, habits and preferences of the individual residents. Activities* must include:
- Independent (self-directed) activities*, in which opportunities are available in the environment enabling a resident to engage spontaneously in an independent activity of interest;
 - Individual activities*, in which a staff person or volunteer engages the resident in a planned and/or spontaneous activity of interest. May include personal care activities as opportunities for purposeful and positive interaction; and
 - Group activities*.

* Note: See definitions at the end of this document.

- B. Provide planned activities – individual and group – that offer opportunities for leisure, productivity and linkage with the larger community. These activities offer access to familiar activities residents enjoyed in the past and encourage use of retained abilities.

The planned activities offered must be a reflection of the interests and preferences of the facility's particular resident population as identified in the dementia care assessments and service plans.

- C. Offer activities that accommodate for variations in resident's mood, energy and preferences. Rather than asking a resident to conform to a set schedule, staff makes appropriate activities available based upon the resident's schedule and individual interests. For example, individuals up at night will have access to staff support, food and appropriate activities.

3. STAFF AND STAFF TRAINING

INTRODUCTION

An essential element in specialized dementia care is the staff – it is the staff that develop and implement the highly specific dementia care service plan and support the individual in their environment. To accomplish this, the staff must be sufficient in number, appropriately trained, have ongoing opportunities for education and support, and demonstrate the skills and knowledge necessary to provide specialized dementia care.

STANDARDS

The facility shall:

- A. Maintain a direct care staff ratio necessary to support at all times residents' physical, psychosocial, spiritual, emotional, health care and safety needs.
- B. Maintain awake staff on the night shift. Staffing will be adequate to respond to the sleeping and waking patterns and needs of residents. Additional staff must be available, as needed, for emergency situations.
- C. Not substitute locked exterior doors or perimeter fences with locked gates for trained staff in sufficient numbers to meet the care and supervision needs of all residents.
- D. Coordinate and/or provide for resident's health care needs by hiring or contracting with: 1) a registered nurse; or 2) a licensed practical nurse working under the supervision of a registered nurse; or 3) an ARNP.

Licensed nursing staff will:

- 1) Provide nursing services as allowed in boarding home regulations and as needed to meet resident needs;
- 2) Provide ongoing health assessment that includes regular observation and assessment of signs of illness or distress;
- 3) Participate as a member of the caregiving team to develop, revise and implement the service plan;
- 4) Be a knowledgeable and available resource to staff regarding resident health care concerns, model appropriate staff/resident/family interaction, and provide assistance and guidance with issues of resident behavior and well-being;
- 5) Provide informal and incidental training to direct care staff related to the changing needs of residents; and, may participate in more structured training; and
- 6) Be available at all times through an on-call system to meet unscheduled needs.

A facility may substitute a physician, or a physician's assistant working under the supervision of a physician to accomplish all or part of the duties above, if desired.

- E. Provide, directly or indirectly, appropriate consultative resources for assessment, specialized dementia care planning, and problem solving for residents identified as having unmet psychological or behavioral needs (e.g., facility staff with expertise or through a cooperative agreement with a local community mental health center or a qualified consultant).

- F. Ensure staff meet the training requirements in WAC 388-112, as applicable, including at a minimum, orientation, basic or modified basic training (e.g., Fundamentals of Caregiving, Modified Fundamentals, or an approved alternative), dementia specialty, and continuing education.
- G. Ensure that each employee who works directly with residents has at least **one hour** of continuing education related to Alzheimer's disease/dementia monthly. This may include classroom training as well as group or individual problem-solving sessions facilitated by professional staff. This monthly requirement will meet the continuing education requirement specified in the boarding home training rules (WAC 388-112).
- H. Within 120 days of hiring or the start of the contract, whichever is later, complete the department's uniform "skills" checklist for each staff working directly with residents to ensure each staff is competent in dementia-specific care strategies, as well as specified personal care skills.
- I. Provide ADSA with a training plan that includes:
 - 1) A plan for getting the administrator and caregivers trained.
 - 2) Identification of who will provide the dementia training (see the minimum instructor qualifications in WAC 388-112-0390). Note that the administrator, designee, or corporate trainer may be exempt from the instructor qualifications if they take the manager dementia class.
 - 3) Identification of the curriculum to be used for each type of training.
 - 4) How continuing education will be provided.

Note: If basic, modified basic, or dementia specialty training will be provided in-house, items 2 and 3 must be documented on the "Facility Based Training Notification Form" which must be sent to ADSA for approval of facility-based training, prior to offering training. A copy may be included in the training plan.

4. ENVIRONMENT

INTRODUCTION

The physical environment and design features of the facility should support the functioning of cognitively impaired residents, accommodate behaviors and maximize functional abilities, promote safety and encourage independence and spontaneous activity of residents.

STANDARDS

The facility shall provide an environment in which:

- A. The level of stimulation is consistent with individuals' needs and preferences.
- B. The areas used by residents have a home-like, non-institutional atmosphere including privacy, comfortable surroundings, and no traditional nursing station or public address system.

- C. Resident bedrooms ensure: (a) resident privacy and (b) individualized space that is decorated or furnished with personal items based on the resident's needs and preferences.
- D. Residents shall have freedom of movement to common areas and to their personal spaces. The facility shall not lock residents in (or out of) their rooms and residents shall have access to their rooms at all times.
- E. Residents shall have independent free access to a secure, inviting, functional outdoor space (e.g., level walking paths, protection from extreme weather).
- F. The safety of residents who wander is monitored and resident egress from the facility is detected immediately by staff (e.g., visual observation, door monitoring devices).
- G. Multiple common areas are available that vary by size and arrangement and that create opportunities for meaningful individual or group activity (e.g., furniture groupings that encourage stopping and spontaneous social interaction; resident kitchen; a garden area; a workshop; paths and walkways that encourage exploration and walking).
- H. Materials and design known to accommodate the cognitive deficits of people with dementia are present and available (e.g., minimize glare and shadows; enhance orientation and way-finding).

5. FAMILY INVOLVEMENT

INTRODUCTION

The involvement of family members is an integral part of specialized dementia care.

STANDARDS

The facility shall:

- A. Encourage family members, as defined by the resident, to participate in the resident's life and the life of the facility unless the resident chooses not to involve them. The facility will recognize and promote each family's involvement based upon resident desires and needs, and the family's desired level of involvement.
- B. In conjunction with the department, will offer and encourage family members to participate in education sessions, support groups or other format of supportive services related to their family member either through direct provision or referral to appropriate resources in the community.
- C. Make ongoing communication and interaction possible between family members, providers, and residents. Responsible family members will be kept informed, their input requested and welcomed, and should be aware of the appropriate communication channels for their questions and concerns.

DEFINITIONS

Specialized dementia care. Specialized dementia care is more than simply meeting the basic health, safety and personal care needs of individuals with dementia. To address the basic needs, the care must focus on the unique desires and preferences of the individual. It is “getting to know” the residents – their histories, personalities, behaviors and routines – that allows basic care needs to be optimally met (with minimal stress reactions or unwanted behaviors). Daily life and care occurs in a milieu that supports each individual in doing what is personally satisfying. Promoting feelings of self-worth and pleasure allow the individual to function at the highest level possible. The caregiving environment – both social and physical – responds to dementia-related behaviors based upon general knowledge and the caregivers’ understanding of each person’s individual needs and wishes.

Specialized dementia care service plan in the context of specialized dementia care refers to the focus on each unique individual (i.e., his/her history, needs, preferences). The dementia care service plan is a tool that identifies specifically what the resident needs and how those needs will be addressed on a daily and ongoing basis.

Free access to an outdoor space means that residents should have direct, unrestricted access to an outdoor area. Residents’ access to the outdoors should not be limited by doors, stairs, or elevators with restricted egress. Residents should not be required to seek staff permission to go outside, nor should staff be required to escort all residents outside.

Activity. In specialized dementia care, an “activity” is any interaction between an individual and the environment, the term “environment” including all of its physical, social and cultural elements. A resident’s activity program includes everything he/she experiences during the day (e.g., a bath, a walk in the garden, a conversation with the cook). It is important to understand that activities are not just the contrived experiences we arrange. They are the normal things we do in the course of each day.

Individual activities are things that the resident enjoys doing with the help of another person. These activities are identified especially for the resident and might include listening to a special tape of favorite music on headphones, going for a walk with a volunteer, doing a certain puzzle the resident knows and enjoys, helping with the laundry, or watching over a facility pet. For some, personal care tasks such as grooming, bathing and dressing are among the most meaningful activities of the day and should be thoughtfully planned and adapted to turn them into pleasurable and affirming opportunities.

Group activities are those designed to meet the needs and abilities of specific residents. The format and content of these groups will be determined by the needs, abilities, interests and preferences of the residents. Larger groups may be appropriate for special occasions such as birthdays, holidays or other occasions when a community group comes to entertain. But some residents are much better served in smaller, more intimate groups; small groups promote a more stable group of peers with whom residents can share common interests and feel comfortable.

Independent (self-directed activities) are those that simply happen spontaneously during the course of a day. This might include social encounters with other residents, staff or visitors. Or, it might include interaction with items of interest in the environment such as the pet dog, a garden table or a newspaper. For individuals with dementia, self-directed activities are encouraged with “props” related to specific interests. For example, workstations might incorporate office-related items at a desk such as a typewriter, envelopes, and catalogs; or might offer the necessary items to promote familiar household tasks such as folding laundry, sweeping or dusting.

SKILLS CHECKLIST INFORMATION SHEET

WHAT IS THE SKILLS CHECKLIST?

1. This skills checklist is an outcome-oriented tool intended to guide you in evaluating the skills of staff members providing specialized dementia care.
2. The skills listed should all have been covered in the facility's training, whether it was the Alzheimer's Association's *Providing Dementia Care*, or Dementia Specialty Training.

WHY DO WE NEED A SKILLS CHECKLIST?

1. A skills checklist is required in the Specialized Dementia Care Program in Boarding Homes *Standards of Care* (section 3H).
2. In the process of completing this checklist, supervisory staff will have the opportunity to identify critical areas of skill in which a staff member performs adequately, or in which a staff member is found lacking.
3. If found lacking, supervisory staff should develop a plan to increase the skill level of that individual staff member through one to one (1:1) support, mentoring, group or individualized instruction.
4. There is no written test required.

WHO MUST HAVE A COMPLETED SKILLS CHECKLIST?

1. All staff that work directly with residents need to be checked off on these skills.
2. The administrator will need to do the checklist if a significant part of his or her job involves working with residents. Please note that the administrator must complete the comprehensive training as stated in the *Standards of Care* (sections 3 F, 3G, 3H).

WHO CAN SIGN OFF ON THE CHECKLIST? HOW IS THE CHECKLIST COMPLETED?

1. The observer should be a supervisor, professional nursing staff, trainer or administrator.
2. To complete the checklist, enter the staff member's name and the name of the person(s) observing the skill.
3. As each skill is observed being performed correctly, the observer initials and dates the item.
4. If an opportunity for a "naturally occurring" observation does not present itself, then the observer may need to set up a staged skills demonstration.
5. Staff who have documentation of completing an approved training do not need to repeat the training, but must complete the checklist.

WHEN IS THE CHECKLIST DONE?

1. Observations may be in the course of regular shift work and in "naturally occurring" caregiving situations.
2. The skills checklist is to be completed within the 120-day requirement as required by the *Standards of Care* (section 3H).

OTHER QUESTIONS, CONTACT*:

- Lynne Korte 360-725-2545; kortelm@dshs.wa.gov
- Marta Acedo 360-725-2549; acedom@dshs.wa.gov
(*you can also reach us at 1-800-422-3263 during business hours)

EXHIBIT A DEMENTIA CARE EXPANSION PROJECT IN BOARDING HOMES

■ SKILLS CHECKLIST

Staff Name: _____

Dementia Curriculum Topic	Initial	Date
1. ALZHEIMER'S DISEASE AND OTHER DEMENTIAS		
a) Caregiver interacts with residents based on knowledge that dementia is a brain disease (e.g. caregiver does not blame resident for behaviors and is patient with resident).		
b) Caregiver interacts with residents based on knowledge of the typical symptoms at various stages of the disease.		
2. COMMUNICATION SKILLS		
a) Caregiver uses both verbal and non-verbal communication skills appropriately (e.g. uses a calm, gentle tone of voice, calls the person by name, uses eye contact and pleasant facial expression).		
b) Caregiver provides step-by-step instructions for tasks, avoiding lengthy explanations.		
3. BEHAVIOR AS COMMUNICATION		
a) Caregiver demonstrates skill in responding to a resident's feelings rather than trying to orient the person to reality (e.g. "you miss your home" rather than "this is your home").		
4. Repetitive Behaviors		
a) Caregiver responds appropriately to repetitive actions, using redirection, providing alternative activity, tolerating repeated questions.		
5. WANDERING		
a) Caregiver appropriately redirects wandering residents back to a secured/safe area.		
b) Caregiver implements the facility's action plan in the event of a missing person.		
6. AGGRESSIVE BEHAVIORS AND CATASTROPHIC REACTIONS		
a) Caregiver uses strategies to decrease and avoid aggressive behaviors (e.g. identifies potential "triggers", intervenes early).		
b) Caregiver demonstrates appropriate responses to aggressive behaviors (e.g. uses distraction, moves vulnerable residents out of harm's way, calls for help when needed).		
c) Caregiver responds appropriately to residents who experience paranoia and hallucinations (e.g. uses reassurance, provides cues, responds to feelings, refers for further evaluation if needed).		

EXHIBIT A DEMENTIA CARE EXPANSION PROJECT IN BOARDING HOMES

■ SKILLS CHECKLIST

Dementia Curriculum Topic	Initial	Date
7. INTIMACY AND INAPPROPRIATE SEXUAL BEHAVIOR		
a) Caregiver uses appropriate responses when a client makes an inappropriate sexual remark or advance (e.g. redirects client, provides alternative activity, requests help when needed).		
b) Caregiver redirects sexual activity that is occurring in a public place (e.g. moves client to private area).		
8. SLEEP DISTURBANCES		
a) Caregiver uses strategies to encourage regular sleeping hours based on understanding of causes of sleep disturbances in dementia (e.g. promotes regular schedule, encourages activity during the day, provides a quiet environment at night).		
9. PERSONAL CARE		
a) Caregiver assists residents effectively with personal care including nail care, oral care, bathing, shampooing, grooming and dressing (e.g. provides step-by-step instructions; provides pleasant, supportive environment during care).		
b) Caregiver utilizes strategies that promote residents' participation in self-personal care (e.g. assists resident rather than performing task for him/her).		
10. TOILETING		
a) Caregiver appropriately assists residents with toileting to decrease incontinence (e.g. provide reminders while preserving resident's privacy).		
11. EATING AND SWALLOWING		
a) Caregiver uses appropriate care strategies that accommodate changes in eating behaviors that occur with dementia (e.g. providing uncluttered environment, minimizing choices, providing verbal assistance).		
12. ACTIVITY/MEANINGFUL INTERACTION		
a) Caregiver supports residents in organized, spontaneous and naturally occurring activities.		
b) Caregiver demonstrates knowledge of residents' personal preferences in activities.		
c) Caregiver engages resident in conversation topics of interest to the resident and encourages resident to participate in activities.		

EXHIBIT A DEMENTIA CARE EXPANSION PROJECT IN BOARDING HOMES

■ SKILLS CHECKLIST

Dementia Curriculum Topic	Initial	Date
13. ENVIRONMENT a) Maintains environmental standards and demonstrates understanding of a supportive environment for people with dementia (e.g. minimizes clutter, provides cues for activities, promotes social interaction in common spaces).		
14. FAMILY/STAFF INTERACTION a) Caregiver communicates appropriately and builds positive relationships with family members (e.g. greets family when they visit, answers questions, makes positive remarks to the family about residents, does not gossip with families about other residents).		
15. CARE FOR THE CAREGIVER a) Caregiver demonstrates an understanding of the importance of self care (e.g. gets assistance when needed, takes scheduled breaks, demonstrates a cheerful attitude).		
16. CULTURAL AND SPIRITUAL ISSUES a) Caregiver works with family to understand cultural needs and utilizes this in working with the resident (e.g. customs, holidays, habits). b) Caregiver demonstrates understanding and respect for religious or spiritual beliefs of residents. c) Caregiver is able to communicate with a person whose English is limited.		

Observer Name(s): _____

Comments:

APPENDIX D: Staff Time Measurement Study Data

STAFF TIME MEASUREMENT STUDY DATA

Facility A

<u>Resident #</u>	<u>Staff Hours Per Day</u>	<u>Rate Per Resident Day</u>			
		<u>Staffing</u>	<u>Operations</u>	<u>Capital</u>	<u>Total</u>
1.	4.42	45.72	15.81	3.89	65.42
2.	2.23	33.95	15.81	3.89	53.65
3.	4.50	46.89	15.81	3.89	66.59
4.	4.10	42.95	15.81	3.89	62.65
5.	3.41	35.74	15.81	3.89	55.44
6.	3.67	38.33	15.81	3.89	58.03
7.	6.07	63.27	15.81	3.89	82.97
8.	4.21	43.64	15.81	3.89	63.34
9.	4.56	47.14	15.81	3.89	66.84
<i>Average:</i>					<i>\$63.88</i>
<i>Range:</i>					<i>\$53.65 - \$82.97</i>

Facility B

<u>Resident #</u>	<u>Staff Hours Per Day</u>	<u>Rate Per Resident Day</u>			
		<u>Staffing</u>	<u>Operations</u>	<u>Capital</u>	<u>Total</u>
1.	4.34	46.56	15.48	3.99	66.03
2.	4.26	45.43	15.48	3.99	64.90
3.	5.11	55.77	15.48	3.99	75.24
4.	4.65	50.41	15.48	3.99	69.88
5.	4.46	47.81	15.48	3.99	67.28
6.	4.53	49.69	15.48	3.99	69.16
<i>Average:</i>					<i>\$68.75</i>
<i>Range:</i>					<i>\$64.90 - \$75.24</i>

APPENDIX D: Staff Time Measurement Study Data

Facility C

<u>Resident #</u>	<u>Staff Hours</u> <u>PerDay</u>	<u>Rate Per Resident Day</u>			
		<u>Staffing</u>	<u>Operations</u>	<u>Capital</u>	<u>Total</u>
1.	4.70	47.22	15.48	3.99	66.69
2.	7.31	73.06	15.48	3.99	92.53
3.	5.84	58.24	15.48	3.99	77.71
4.	4.86	49.12	15.48	3.99	68.59
5.	5.19	53.32	15.48	3.99	72.79
6.	5.85	61.24	15.48	3.99	80.71
7.	4.87	49.04	15.48	3.99	68.51
8.	6.36	64.61	15.48	3.99	84.08
9.	5.36	53.51	15.48	3.99	72.98
				<i>Average:</i>	<i>\$76.07</i>
				<i>Range:</i>	<i>\$68.51 - \$92.53</i>

Facility D

<u>Resident #</u>	<u>Staff Hours</u> <u>PerDay</u>	<u>Rate Per Resident Day</u>			
		<u>Staffing</u>	<u>Operations</u>	<u>Capital</u>	<u>Total</u>
1.	4.82	51.91	15.48	3.99	71.38
2.	6.28	65.00	15.48	3.99	84.47
3.	6.24	68.86	15.48	3.99	88.33
4.	5.52	60.16	15.48	3.99	79.63
5.	5.87	66.04	15.48	3.99	85.51
6.	6.37	67.93	15.48	3.99	87.40
7.	4.87	53.13	15.48	3.99	72.60
8.	3.88	42.45	15.48	3.99	61.92
				<i>Average:</i>	<i>\$78.91</i>
				<i>Range:</i>	<i>\$61.92 - \$88.33</i>

APPENDIX D: Staff Time Measurement Study Data

Facility E

<u>Resident #</u>	<u>Staff Hours PerDay</u>	<u>Rate Per Resident Day</u>			
		<u>Staffing</u>	<u>Operations</u>	<u>Capital</u>	<u>Total</u>
1.	3.71	40.67	15.48	3.99	60.14
2.	3.40	37.46	15.48	3.99	56.93
3.	4.50	51.55	15.48	3.99	71.02
4.	3.77	41.25	15.48	3.99	60.72
5.	4.71	54.21	15.48	3.99	73.68
6.	3.21	35.58	15.48	3.99	55.05
<i>Average:</i>					\$62.92
<i>Range:</i>					\$55.05 - \$73.68

Facility F

<u>Resident #</u>	<u>Staff Hours PerDay</u>	<u>Rate Per Resident Day</u>			
		<u>Staffing</u>	<u>Operations</u>	<u>Capital</u>	<u>Total</u>
1.	5.90	60.39	15.48	3.99	79.86
2.	7.20	75.32	15.48	3.99	94.79
3.	6.31	64.01	15.48	3.99	83.48
4.	5.72	59.00	15.48	3.99	78.47
5.	5.04	52.04	15.48	3.99	71.51
6.	6.24	63.39	15.48	3.99	82.86
<i>Average:</i>					\$81.83
<i>Range:</i>					\$71.51 - \$94.79

Home and Community Boarding Home Cost Survey
 01/01/2002 through 12/31/2002
Return To:
 Ben Wang-ADSA
 P.O. 45600-Olympia, WA 98504
wangby@dshs.wa.gov
 360.725.2439 FAX 360.725.2641

1 Facility Name: _____
 2 SSPS Provider# _____
 3 County: _____
 4 Contract Type: ARC EARC AL GroupHome AFH None

STAFFING PATTERN

Position Title		A	WEEKLY HOURS							Total Weekly Hours
		HOURLY WAGE	SUN	MON	TUE	WED	THR	FRI	SAT	
DIRECT CARE										
5	RN									0.00
6	LPN									0.00
7	Social Worker									0.00
8	Caregiver									0.00
9										
10										
TOTAL DIRECT CARE			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ACTIVITIES										
11	Activities Director									0.00
12	Activities Assistant									0.00
13										
14										
TOTAL ACTIVITIES			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DIETARY										
15	Manager									0.00
16	Cook									0.00
17	Food Services Worker									0.00
18	Food Preparation Worker									0.00
19										0.00
20										0.00
TOTAL DIETARY			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
HSKPNG / MAINT										
21	Housekeeping Superv									0.00
22	Housekeeping									0.00
23	Maintenance Superv									0.00
24	Maintenance									0.00
25										0.00
26										0.00
TOTAL HSKPG / MAINT			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
ADMINISTRATION										
27	Administrator									0.00
28	Business Mgr									0.00
29	Receptionist									0.00
30	Marketing									0.00
31										0.00
32										0.00
TOTAL ADMINISTRATIVE			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL FACILITY DAILY HOURS			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL FACILITY DAILY WAGES										

COST SURVEY DATA

Table 1 displays the daily average facility rate for staffing, operations and capital costs for each of the six providers reporting.

Table 1

	FACILITY 1	FACILITY 2	FACILITY 3	FACILITY 4	FACILITY 5	FACILITY 6
Staffing	47.92	69.30	57.13	45.01	64.47	35.12
Operations	19.25	21.14	17.82	24.02	30.44	18.09
Capital	<u>3.99</u>	<u>3.99</u>	<u>5.19</u>	<u>2.71</u>	<u>4.55</u>	<u>3.89</u>
Total	\$71.16	\$94.42	\$80.15	\$71.74	\$99.47	\$57.10

Facility 1 has 52 licensed beds. It provides dementia care and services each day to 46 residents, for an average daily rate per resident of \$71.16. Total facility daily average staff hours are 139 and the average staff hours per day for each resident is 3.04.

Facility 2 has 65 licensed beds and provides dementia care and services each day to 57 residents, for an average daily rate per resident of 94.42. Total facility daily average staff hours are 258 and the average staff hours per day for each resident is 4.54.

Facility 3 has 85 licensed beds and provides dementia care and services each day to 75 residents, for an average daily rate per resident of 80.15. Total facility daily average staff hours are 315 and the average staff hours per day for each resident is 4.20.

Facility 4 has 16 licensed beds and provides dementia care and services each day to 14 residents, for an average daily rate per resident of 71.74. Total facility daily average staff hours are 50.75 and the average staff hours per day for each resident is 3.63.

Facility 5 has 15 licensed beds and provides dementia care and services each day to 13 residents, for an average daily rate per resident of 99.47. Total facility daily average staff hours are 68.28 and the average staff hours per day for each resident is 5.25.

Facility 6 has 20 licensed beds and provides dementia care and services each day to 18 residents, for an average daily rate per resident of 57.10. Total facility daily average staff hours are 45.6 and the average staff hours per day for each resident is 2.53.

August 28, 2003

< Pilot Address >

Dear <Pilot Project Administrator>,

At our recent meeting related to the *Dementia Care Pilot Project for Boarding Homes*, we informed you that the legislature has directed the department to submit a report on the pilot project (Chapter 231, Laws of 2003, Section 9). One of the elements they're requesting is the "actual costs of providing dementia care and services to residents under the dementia care pilot program". As you know, communicating this information to the legislature is of great importance to providers, residents and the department alike.

The Survey

You may already know that another effort is being initiated on a broader level to attain similar information from all boarding home operators across the state. The Home and Community Services Rates Division will be surveying all Washington state licensed boarding homes in September 2003. We have chosen to use the same survey format so that the information will be compatible with the larger bank of information we will be gathering over time. The difference between these efforts is that we are only interested in your costs of operations for residents of specialized dementia care, both private and Medicaid.

Enclosed is a copy of a survey form designed to gather all cost data related to the operation of your facility. We will need your responses by **September 25, 2003**. Please submit your completed survey to: Ben Wang – ADSA – P.O. Box 45600 – Olympia, WA 98504-45600

The results of this cost survey will be used to verify the benchmarks used by the department to reflect actual costs for wages, payroll taxes and fringe benefits, operations and capital costs. In addition to publishing these results in the report submitted to the Legislature in December 2003, having this information available is vital to budget negotiations in the coming months.

APPENDIX E: Letter and Survey to Boarding Home Providers

I hope you find the enclosed form and instructions clear and this information is readily available. Should you have any questions about how to complete this cost survey, please call Dick Rosage at 360.725.2442 / Ben Wang at 360.725.2439. If you have questions related to the Dementia Care Pilot Project and/or the legislative report being developed, please call Lynne Korte at 360.725.2545.

Cordially,

Marta Acedo, Office Chief
Training, Communications and Development
Home and Community Services Division

cc: Lynne Korte